

POLICY OF	POLICY NUMBER	PAGE NUMBER
STATE OF DELAWARE	E-09	1 OF 2
DEPARTMENT OF CORRECTION	RELATED NCCHC/ACA STANDARDS: P-E-09/4-4400 (ESSENTIAL)	
CHAPTER: 11 HEALTH SERVICES	SUBJECT: SEGREGATED INMATES	
APPROVED BY THE COMMISSIONER:		
EFFECTIVE DATE: 11-19-07		

PURPOSE:

To insure inmates placed in segregation do not have any contraindicating medical conditions and their health status does not deteriorate during confinement.

POLICY:

1. Correctional staff will inform healthcare staff when an inmate is placed in segregation.
The inmate's medical record will be reviewed prior to or within one (1) hour of placement in segregation for medical, dental or mental health conditions. Those whose conditions which would be contradictory to confinement or would require special accommodations – severely mental ill, diabetics with frequent episodes of hypoglycemia, infirmity care or higher will be identified by medical.
2. Security will be advised regarding contraindications or special accommodations for an inmate placement in segregation.
3. Findings will be documented in the inmate's medical record.
4. Inmates segregated, as defined above, will be monitored daily by medical staff and at least three (3) days a week by mental health staff.
5. Segregated inmates without the above problems, will be monitored weekly by mental health staff.
6. Inmates placed in segregation, who have been receiving mental health treatment, will be referred to mental health for follow up. Medical staff reviewing chart prior to placement will complete immediate mental health referral for inmates placed in segregation and previously receiving mental health services.

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7. Documentation of rounds is made on an individual sheet for each inmate in segregation.
8. Clinical encounters for healthcare are documented in the individual's medical record.

References:

National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-E-09

Segregation Record Review And Visit Log	
Date notified: _____ Time notified: _____	
Existing medical conditions precluding housing in segregation: ρ No ρ Yes If yes, describe:	Security notified: ρ Not indicated ρ Yes Date: _____ Time: _____
Currently receiving mental health services: ρ No ρ Yes	Mental Health notified of admission to segregation: ρ Not indicated ρ Yes Date: _____ Time: _____
Currently on medications: ρ No ρ Yes	Arrangements made for medication administration: ρ Not indicated ρ Yes
Signature _____	Date _____ Time _____

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
January																															
February																															
March																															
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June																															
July																															
August																															
September																															
October																															
November																															
December																															

Nurses sign & initial:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

NAME: _____	ID #: _____	DOB: _____	YEAR: _____
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[illegible]

Administrative Segregation Mental Health Progress Note

Observations:

Mood: ☐ appropriate ☐ inappropriate **Thought:** ☐ appropriate ☐ inappropriate
Behavior: ☐ appropriate ☐ inappropriate **Appearance:** ☐ appropriate ☐ inappropriate
☐ No exacerbation of mental health symptoms observed ☐ No suicide risk factors reported or observed

Self report of mental status:

Other Comments: _____

Date: _____ **Clinician's Signature:** _____

Observations:

Mood: ☐ appropriate ☐ inappropriate **Thought:** ☐ appropriate ☐ inappropriate
Behavior: ☐ appropriate ☐ inappropriate **Appearance:** ☐ appropriate ☐ inappropriate
☐ No exacerbation of mental health symptoms observed ☐ No suicide risk factors reported or observed

Self report of mental status:

Other Comments: _____

Date: _____ **Clinician's Signature:** _____

Observations:

Mood: ☐ appropriate ☐ inappropriate **Thought:** ☐ appropriate ☐ inappropriate
Behavior: ☐ appropriate ☐ inappropriate **Appearance:** ☐ appropriate ☐ inappropriate
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☐ No exacerbation of mental health symptoms observed ☐ No suicide risk factors reported or observed

Self report of mental status:

Other Comments: _____

Date: _____ **Clinician's Signature:** _____

Inmate Name:	Inmate Number:
Institution:	Date of placement: